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	155269	A. BUILDING 01 B. WING	05/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST LAKE NURSING AND REHABILITATION CENTER	1900 JEANWOOD DR ELKHART, IN 46514

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/31/12 Facility Number: 000169 Provider Number: 155269 AIM Number: 100267100 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, East Lake Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and in all areas open to the corridor. The facility	K0000	**The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.** **Due to the relative low scope and severity of this survey, the facility respectfully requests a desk review in lieu of a post-survey revisit on or after June 30, 2012.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	has a capacity of 160 and had a census of 137 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 06/05/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 14 corridor doors in the 200 Hall would resist the passage of smoke. This deficient practice could affect any resident, staff or visitor in the vicinity of the Unit 2 Mechanical Room in the 200 Hall. Findings include: Based on observation with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:15 p.m. on 05/31/12, the entry door to the Unit 2 Mechanical Room in the 200 Hall was warped at the bottom twelve inches of the door leaving a one inch gap between the door and the door frame which was not smoke resistant. Based on interview at the time of observation, the Maintenance	K0018	**K018 – Mechanical Door Unit 2** It is the practice of this provider that all doors will resist the passage of smoke. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *No residents were directly affected by the practice. The door to the mechanical room in Unit 2 will be replaced by Builders Enterprise by June 30, 2012.* ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:***	06/30/2012

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	Supervisor acknowledged the Unit 2 Mechanical Room entry door was warped and not smoke resistant at the bottom twelve inches of the door. 3.1-19(b)		*Residents in Unit 2 were the only residents capable of being affected by the practice. The door to the mechanical room in Unit 2 will be replaced by Builders Enterprise by June 30, 2012.* ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** *The door to the mechanical room in Unit 2 will be replaced by Builders Enterprise by June 30, 2012. The maintenance director will perform monthly door checks to ensure they create a smoke proof barrier.* ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** *The maintenance director will report the door inspections to the CQI Committee monthly for 6 months or until a pattern of consistent compliance is achieved with a subsequent plan developed and implemented as indicated.* ***By what date the systemic changes will be completed:*** Compliance date: June 30, 2012	

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K0052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to document 1 of 1 fire alarm systems was maintained in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the	K0052	**K052 – Fire Alarm Sensitivity** It is the practice of this provider that the fire alarm system is installed, tested, and maintained according to standard. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *No residents were affected by the practice due to the fire alarm system performing continual sensitivity tests due to it being a "smart panel system".* ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** *No other residents had the potential to be affected by the practice due to the fire alarm system performing continually sensitivity tests due to it being a "smart panel system".*	06/30/2012

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	following methods: (1) Calibrated test method (2) Manufacturer ' s calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced. NFPA 72, 7-5.2.2 states a permanent record of all inspections, testing and maintenance shall be provided. This deficient practice could affect all residents, staff and visitors. Findings include: Based on a record review with the Maintenance Supervisor from 10:00 a.m. to 11:45 a.m. on 05/31/12, no documentation of sensitivity testing of facility smoke detectors was available for review. Based on interview at the time of record review, the Maintenance Supervisor stated the facility installed an		***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** East Lake has an Edwards Intelligent Fire Panel. The Edwards Intelligent system computer constantly monitors the systems smoke detectors and adjusts them as needed. When a smoke detector gets out of sensitivity range and can no longer be automatically adjusted, it triggers a "system trouble" signal, alerting the user that the smoke detector needs to be changed out. An IEI (Integrated Electronics of IN) tech will come to East Lake to download the smoke detector sensitivity information onto his computer. They will then print off the information so we will have a hard copy of the report. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** *Maintenance Director will report sensitivity tests results from IEE to CQI Committee annually.* ***By what date the systemic changes will be completed:*** Compliance date: June 30, 2012	

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	addressable fire alarm panel four years ago which continuously performs a systems and sensitivity test on all facility smoke detectors and acknowledged no documentation of sensitivity testing of facility smoke detectors was available for review. 3.1-19(b)			

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K0056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observations and interview, the facility failed to provide sprinkler coverage for 2 of 7 combustible exterior canopies which were each wider than 4 feet. NFPA 13, 1999 Edition, Section 5-13.8.1 requires sprinklers shall be installed under combustible exterior roofs or canopies exceeding 4 feet in width. This deficient practice could affect residents, staff and visitors using the 200 Hall exit and the 500 Hall exit. Findings include: Based on observations with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:15 p.m. on 05/31/12, the exterior canopies at the 200 Hall exit and the 500 Hall exit each extended six feet from the building, each canopy was not provided with automatic	K0056	**K056 – Fire Sprinkler Coverage** It is the practice of this provider that the sprinkler system provides coverage for all necessary portions of the building. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *The outside overhangs on 200 Hall and 500 Hall will have sprinklers installed.* ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** *Maintenance Director inspected all outdoor overhangs to ensure that*	06/30/2012

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	sprinklers, and were of wood construction. Based on interview at the time of the observations, the Maintenance Supervisor stated the 200 Hall exit canopy and the 500 Hall exit canopy were each of combustible construction, each extended more than four feet from the building and each exterior canopy was not provided with automatic sprinklers. 3.1-19(b)		*facility was in compliance and overhangs over 4 feet had sprinklers installed.* ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** *Fire sprinklers over 200 and 500 hall overhangs to be installed PIPE Inc by June 30, 2012.* ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** *Environmental/Life Safety CQI audit tool to include sprinkler head placement and functionality. This audit tool to be reported to the CQI Committee every 2 months for review and compliance.* ***By what date the systemic changes will be completed:*** Compliance date: June 30, 2012	

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K0062 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure 2 of 2 private fire hydrants were continuously maintained in reliable operating condition and inspected and tested periodically. NFPA 25, 1998 Edition, the Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at Section 4-2.2.4 requires dry barrel hydrants to be inspected annually and after each operation. Hydrants shall be inspected, and the necessary corrective action shall be taken. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on review of the P.I.P.E. "Hydrant Flow Test Report" dated 02/21/11 with the Maintenance Supervisor during record review from 10:00 a.m. to 11:45 a.m. on 05/31/12, the most recent inspection of the facility's two fire hydrants was performed on 02/21/11 and not within the last twelve months. Based on interview at the time of record review, the Maintenance Supervisor stated no other	K0062	**K062 – Fire Hydrants** It is the practice of this provider that that all fire hydrants are continuously maintained in reliable operating condition and tested. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *The 2 fire hydrants will be serviced and inspected by Kropp Fire Protection by June 30, 2012.* ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** *All residents had the potential to be affected by the practice. Both fire hydrants to be serviced and inspected by Kropp Fire Protection by June 30, 2012.* ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:***	06/30/2012

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	fire hydrant inspection documentation was available for review and acknowledged it has been more than twelve months since the last annual inspection of the facility's two fire hydrants. 3.1-19(b)		*Both fire hydrants to be serviced and inspected by Kropp Fire Protection by June 30, 2012. Fire hydrant inspection and servicing to be added to maintenance's annual preventative maintenance.* ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** *Maintenance Director to report annual preventative maintenance schedule results to the CQI Committee annually.* ***By what date the systemic changes will be completed:*** Compliance date: June 30, 2012	

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K0067 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 Based on record review, observation, and interview; the facility failed to ensure 3 of 3 fire dampers in the facility were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires heating, ventilating and air conditioning (HVAC) ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all residents, staff and visitors. Findings include: Based on a review of the Dynamic Mechanical Services (DMS) letter to the facility dated 03/08/12 and "Service Order" dated 11/03/10 during record	K0067	**K067 – Fire Damper Testing** It is the practice of this provider that all fire dampers be inspected and tested per regulations. ***What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:*** *All three fire dampers in the HVAC will be inspected and tested every 4 years.* ***How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken:*** *The practice had the potential to affect all residents. All three fire dampers in the HVAC will be inspected and tested every 4 years.* ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:*** *Maintenance Director will add all*	06/30/2012

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	review with the Maintenance Supervisor from 10:00 a.m. to 11:45 a.m. on 05/31/12, documentation of fire damper testing performed within the last four years did not verify all dampers were operated to fully close. The 03/08/12 letter stated "the fire dampers were visually inspected on 03/01/12 and all are operating fine" and the 11/03/10 "Service Order" stated "inspected all fire dampers in attic in hallways, all are open and all have proper heat linkage, none are blocked." The Maintenance Director contacted DMS by telephone at 11:30 a.m. on 05/31/12 to verify what level of service was performed during each of the two inspections, and acknowledge DMS' inspections do not involve operation of each fire damper to verify they fully close. Based on interview at the time of record review, the Maintenance Supervisor acknowledged the facility does not have documentation every four years to show each fire damper will fully close. Based on observations with the Maintenance Supervisor during a tour of the facility from 11:45 a.m. to 2:15 p.m. on 05/31/12, a total of three fire dampers were installed in the HVAC ductwork above the ceiling in the central corridor by the main entrance. 3.1-19(b)		*fire dampers to preventative maintenance schedule for every 4 years. Dampers to be inspected and tested by Michiana Sheet Metal by June 30, 2012.* ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:*** *Maintenance Director to report damper inspections and testing results to CQI Committee every 4 years as required.* ***By what date the systemic changes will be completed:*** Compliance date: June 30, 2012	

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